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Determinants of Help-Seeking Behaviours among Persons with Depression in Kyaka II Refugee Settlement Camp, Kyegegwa District, Uganda

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Abstract

Background: Depression is one of the leading contributors of the burden of disease globally and in low- and middle-income countries, and refugees are at increased risk for mental health problems due to forced migration from their home countries and other traumatic experiences.

Objectives: To explore the determinants of help-seeking behaviours among persons with depression in Kyaka II Refugee Settlement Camp in Kyegegwa District. Specifically, the study examined the personal and health system factors that influence the help-seeking behaviours among refugees suffering from depression.

Methods: The study was cross-sectional, descriptive and analytical, both qualitative and quantitative in approach. A sample of 237 refugees newly diagnosed with depression in Kyaka II Refuge Settlement Camp in Kyegegwa District was studied. Data from primary respondents was collected by survey method using researcher-administered questionnaire and analysis was done.

Results: The demographic factors that were found to have an influence on help-seeking behaviour were gender (p=0.028), marital status (p=0.001) and religion (p=0.002). Indeed, religion significantly influenced the help-seeking behaviors of persons with depression (COR=2.381, 95% CI=1.359-4.172, p=0.002), implying that those who were protestants were at least two times more likely to seek help for depression from a health facility than those who belonged to other religions. There is no significant between most health system factors and help seeking behaviours, except receiving services when needed (p=0.000) and experience at healthcare facility (p=0.000).

Conclusion: At Kyaka II Refuge Settlement Camp in Kyegegwa, refugees and asylum seekers suffering from depression try out several measures in seeking help for their depression predicament. However, only a sizeable proportion of them seek professional care on realizing that they are suffering from depression. Many of them seek relief from spiritualists/religious leaders and traditional healers.

Keywords: Help-seeking Behaviours; Depression; Refugee; Asylum Seekers

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Introduction

Background of the Study

Help-seeking behaviour involves interpersonal interactions to obtain relevant understanding and advice and supportive action in response to a problem or health state of a person [1]. In the context of this study, it refers to the place where a person first goes to in search for help when he or she has depression. These are categorized into: gazetted health facility and un-gazetted places (any place which is not a health facility mandated to treat depression). Depression is a state of low mood and aversion to

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activity. It can affect a person's thoughts, behaviour, motivation, feelings, and sense of well-being, with features such as sadness, difficulty in thinking and concentration and a significant increase or decrease in appetite and time spent sleeping [2]. According to Steel, et al. (2014), depression is an important public health issue, with high prevalence globally, and with substantial impact on daily functioning of the affected persons [3]. This condition is associated with markedly reduced quality of life in patients and their relatives, as well as high economic burden. Effective and evidence-based treatments for depression, like psychotherapy and pharmacological treatment, are available. However, many people do not receive professional care for their symptoms [4]. Considering the high burden of depression and the large treatment gap among refugees, it is important to identify the determinants of help-seeking behaviors of persons with depression in a refugee camp.

Depression is one of the leading contributors of the burden of disease globally and in low- and middle income countries (LMIC), and is projected to be, overall, the second leading cause of burden of disease by 2020 [4]. Global estimates of the number of people with depression that receive help range from 28 to 60% depending on definition and measurement used [4]. Depression affects more people than any other mental disorder, and is the leading cause of disability worldwide in terms of total years lost due to disability [5].

According to the World Federation for Mental Health (2012), depression affects more than 300 million people worldwide and is the second leading cause of global burden of diseases, which was also projected to be the first by 2020 [6,7]. Depression constitutes 40% of diagnosis of mental illnesses [8]. The lifetime prevalence ranges from 11 to 15% and its 12-month prevalence is about 6% in the global setting [9]. Moreover, people with depressive disorders have 40% greater chance of premature death and less quality of life than the general population [10]. Major depression impacts daily quality of life and is the psychiatric diagnosis most commonly associated with suicide. The lifetime suicide risk among patients with untreated depressive disorder is nearly 20% [11].

World over, refuges are more prone to depression, with estimates ranging between 41% and 50%, higher than the average rates of depression in the general population [12]. Refugees are at risk for mental health problems due to forced migration from their home countries and other traumatic experiences. For example, Karenni refugees residing along the Burmese-Thai border had a higher prevalence of depression (41%) and anxiety (42%) in comparison to the rates in the US general population (7-10% respectively) [13]. Traumatic events related to harassment, lack of basic needs and violence is strongly associated with depression. In addition to pre-existing stressors and traumatic experiences, refugees resettled to a third country may experience post-resettlement problems ranging from difficulties in finding jobs and accessing services to cultural and linguistic isolations, all of which could increase risk for mental illness such as depression [12]. In a systematic review, it was found that the highest prevalence were post-traumatic stress disorder (3-88%), depression (5-80%) and anxiety disorders (1-81%) with large variation [14].

In a recent systematic review it was estimated that the prevalence of mental disorders (depression, anxiety, post-traumatic stress disorder, bipolar disorder and schizophrenia) was 22.1% (95% UI 18.8–25.7) at any point in time in the conflict-affected populations [15]. In an earlier review of studies of major depression with 200 or more refugees who had resettled to western countries, about 5% were diagnosed with major depression [16]. High rates of depression have been reported many years after that. For example, in 2010, in response to the high rates of depression, which led to suicide attempts and suicide cases in Bhutanese refugee camps in Nepal, the International Organization for Migration (IOM) conducted an assessment of psychological needs and suicide risk factors of Bhutanese refugees in the camps and found similar results [17]. In 2017, an estimated 11 million U.S. adults aged 18 years or older had at least one major depressive episode with severe impairment. This number represented 4.5% of all U.S adults [18,19]. In Netherlands, out of a total sample, 65% (n=66) received help in the past six months. Results showed that respondents with a longer duration of symptoms and those with lower personal stigma were more likely to seek help. Other determinants were not significantly related to help-seeking in the study [20].

However, depression is a global medical issue, not just for citizens of the developed world, but also for millions of people in developing nations [21]. Although depression may be misperceived as a "first-world problem, it is an international problem and the world's greatest burden of disease [22,23]. For many refugees in developing nations, life presents a host of unique triggers such as conflict and disease epidemics, in addition to more conventional and day-to-day challenges. As a result, depression in developing nations is equally prevalent as or even often more prevalent than depression in wealthier nations [24]. With an increasing number of refugees migrating across continents, the crisis of depression is very apparent [19].

In Uganda, depression is among the most common chronic illnesses in Uganda with prevalence rates of up to 26% [25]. It is more common among the poor, unemployed, alcohol and drug abusers and people living with HIV and Post traumatic Stress Disorder (PTSD), especially among refugee communities [25]. At Kyaka II Refuge Settlement Camp in Kyegegwa District, depression is among the top-most condition managed at the nearby health facility (Bujubuli Health Centre III), with records indicating an increasing number of refugees attending the health facility with depression, many whom go to the health facility late. Understanding the help-seeking behaviours of persons with depression in Kyaka II Refuge Settlement Camp in Kyegegwa District is essential for developing culturally appropriate resources and intervention programs to improve quality of life for the patients, their caretakers and the general refugee population.

Broad Objective

To explore the determinants of help-seeking behaviours among persons with depression in Kyaka II Refuge Settlement Camp in Kyegegwa District.

Specific Objectives

1. To describe the help-seeking behaviours of persons with depression in Kyaka II Refuge Settlement Camp in Kyegegwa District
2. To determine the personal factors that influence the help-seeking behaviours of persons with depression in Kyaka II Refuge Settlement Camp in Kyegegwa District
3. To explore the health system factors that influences the help-seeking behaviours of persons with depression in Kyaka II Refuge Settlement Camp in Kyegegwa District.

REVIEW OF LITERATURE

Help-seeking behaviours of persons with depression

The Depression poses many dangers, burdening people with hopelessness and various forms of symptoms that require them to go seeking for help [13]. Low help seeking is the main reason that increases the burden and complexity of depressive disorders and there is limited evidence on the professional help-seeking behaviour of individuals with depression, especially in low-income settings [26]. In attempts to quell the pain, the victims try out so many things to seek relief. Some turn to alcohol, drugs, and other harmful behaviors that endanger them even further. However, some seek professional mental help [27].

Boerema et al. (2016) conducted a study to find out the determinants of help-seeking behavior in depression [20]. More than a half of the participants received help for psychological problems in the past six months. Of these, 26% received help from general health care (general practitioner, social work, medical specialist) and 15% of them received help from specialized mental health care (psychiatrist, psychologist, clinic for alcohol or drugs abuse, mental health institution, psychiatrist in hospital). The majority, 59% received help in both settings.

In another study, Melak et al. (2018) explored the health care seeking behaviours for depression in Northeast Ethiopia [28]. The study reported low level of professional help-seeking behaviour, as is the cases in some other studies in different countries. Among the total participants with depressive symptoms, only 25.66% of them did seek professional help. Though depression has such a high magnitude and burden, individuals with depression had a low level of professional help-seeking behaviours. Mostly, individuals with depression are reluctant to seek help from mental health professionals; they rather seek informal help from friends, family and traditional healers before getting professional help as the problem gets more complicated [29].

According to another study, the rate of seeking help from professionals for depression is below 25% in the global setting [6]. Further, according to the WHO survey of mental health service use for anxiety, mood disorders, and substance use disorders, the magnitude of seeking professional help within 12 months of onset of mental illness was from 1.6% in Nigeria to 17.9% in the USA [10]. Previous evidence indicated that help-seeking behaviour was from 17 to 47% in different parts of the world [26,30]. From those who do seek professional help, a small proportion of them get specialized mental health care as indicated by 5.7% in South Africa, 7.7% in Mexico, and 9.5% in Iran [18,31,32].

In Ethiopia, professional help-seeking behaviour was reported by 22.9% of individuals with depression [33]. It is common to try many alternative traditional and religious helps before actual health care seeking for symptoms of mental illness including depression [33]. According to another study in Ethiopia, thirty-one percent of patients seeking care from priests/holy water/church and fear of stigma was the major reason to not to seek professional help [34].

Personal factors influencing help-seeking behaviours of persons with depression

Help-seeking behavior among persons with depression is dependent on a number of factors, some of them personal. According to the study by Melak et al. (2018) about health care seeking behaviour for depression in Northeast Ethiopia, professional help-seeking behaviour was affected by personal factors such as common cultural beliefs in traditional medicine [28]. Such beliefs have been reported to be common in lower and middle-income counties [35]. On the other hand, individuals with depressive symptoms also prefer support from family members and close friends [29]. However, considering depression as a treatable illness is one of the deriving factors to seek professional help. Nonetheless, more than half of the participants did not consider depressive symptoms as illness, which affected their help-seeking behavior [29].

The severity of depressive symptoms was significantly associated with the level of professional help-seeking behaviour. The odds of seeking help from professionals for participants with moderate and moderately severe depressive symptoms were 2.54 and 7.67 times more as compared with participants with mild symptoms, respectively. Functional impairment and physical complaints in addition to the loss of roles in the community in case of severe depressive symptoms were also found to be important driving factors for seeking help. This finding was supported by studies done in Finland and South Africa [36,37].

According to another study, stigma towards depressive symptoms greatly affected help-seeking behavior. As indicated, more than half of the participants reported perceived self and public stigma, which negatively affected professional help-seeking behavior among majority of the participants [38]. Females were 2.8 times more likely to seek professional help for their depressive symptoms as compared with males. Traditional decision-making power and greater control of social status in men than women make it difficult to accept the diagnosis of depression, which also leads them to lower help-seeking behaviour for their depressive symptoms [38]. This finding was supported by a study in Finland [39].

According to the study by Boerema, et al. (2016) about the determinants of help-seeking behaviour in depression, univariable and multivariable logistic regression analyses were conducted to

examine the association between help-seeking behaviour and determinants among people with a major depressive disorder [20]. The Univariable regression analyses showed significant odds ratios (OR) for duration of symptoms (OR=2.60; 95 % CI=1.05–6.41; p=0.03) and personal stigma (OR=0.89; 95% CI=0.83–0.96; p=0.005). After univariable analyses, a backward multivariable analyses was performed to determine the effect of individual predictors controlled for each other. The final model showed significant odds ratios for duration of symptoms (OR=2.80; 95% CI=1.06–7.37; p=0.03) and personal stigma (OR=0.90; 95% CI=0.84–0.98; p=0.009). People who received treatment were more likely to experience a longer duration of symptoms and were less likely to experience personal stigma.

According to the study by Melak, et al. (2018) in Ethiopia, being female [adjusted odds ratio (AOR)=2.769, 95% CI (1.280, 5.99)], current alcohol drinking [AOR=2.74, 95% CI (1.265, 5.940)], co-morbid medical-surgical illness [AOR=4.49, 95% CI (1.823, 11.071)], perceiving depression as illness [AOR=2.44, 95% CI (1.264, 4.928)], having moderate depressive symptoms [AOR=2.54, 95% CI (1.086, 5.928)] and moderately severe depressive symptoms [AOR=7.67, 95% CI (2.699, 21.814)] were significantly associated with help seeking behaviour of participants [28].

Current alcohol drinking problem has also been significantly associated with professional help-seeking behavior for depressive symptoms. Drinking has been found to aggravate the symptoms of depression and functional impairment makes the person seek any help from health professionals [40].

Gender, marital status, education and severity of illness symptoms have been associated with help seeking for persons with depression [26,30,41]. However, unlike these studies, marital status and educational status were not statistically significant in the Chen, et al. (2013) study [40]. Further, according to the study by Chen, et al. (2013), the main finding that duration of symptoms was associated with increased health care utilization, is consistent with previous research [30,40]. This finding suggests that people seek help when their symptoms persist for a longer period of time. This is not necessarily an undesirable outcome, as previous research in first onset depressed patients from the community has shown that 50% remitted within 3 months [42]. This supports the idea of watchful waiting in those with a first episode of depression and a short duration of symptoms.

However, this is probably less suitable for people with a chronic or recurrent depression who are at higher risk for long-term impairments and negative consequences from depression [38]. In addition, research has shown that recovery rates for depression decline rapidly after 3 months, supporting the idea that long treatment delays may be harmful to patients [38]. More research in people with a first onset of depression and a recurrent form of depression is necessary to investigate the optimal time to seek professional help.

Other personal factors, like severity of symptoms and co-morbid anxiety, have not been found to be related to help-seeking behaviours even though other studies suggest that they increase service use in people with depression [43,44]. The direction of the results in these studies is in line with previous findings. However, some of them lacked statistical power due to a small sample size. Another potential reason for lack of a relationship between help-seeking and other personal factors is that study participants were those with relatively high co-morbidity regarding medical illness and anxiety disorders, suggesting that the need of treatment in both groups is relatively high.

According to another study, there was small association between personal stigma and patient's preference to deal with depression alone was found [45]. This suggests that people with higher personal stigma, may be more inclined to handle problems by themselves and are, therefore, less likely to seek professional help. Other predisposing factors were not related to help-seeking. These results contradict previous research that showed that younger people, those who experience more loneliness, those scoring higher on neuroticism and people who live without a partner are more inclined to use health services [39,43]. This may, again, be explained by the high co-morbidity in the same [45].

There is some evidence that illness severity is a prompt reason to seek help, meaning that in people with high co-morbidity, predisposing factors may be less important than need factors [30]. Furthermore, there is little difference between the help-seeking and non-help-seeking group with respect to predisposing factors. In addition, the majority of people in both the help-seeking and non-help seeking group experience loneliness, suggesting that other factors than predisposing or personal factors are important in this particular group, like for example previous experiences with help-seeking [30].

The above studies have several strengths and limitations. For example, people with chronic depression have more questions on how to prevent another episode, while people with a first time episode ask for more information about how to cope with depression in daily life [40]. Furthermore, people with a chronic depression may be more demoralized and have negative expectations about the outcome of treatment, which may influence their willingness to seek help [40]. These different factors have potential effect on help-seeking in depression.

Health system factors influencing the help-seeking behaviours

Treatment gap between the number of people with mental disorders and the number treated represents a major public health challenge. A recently published WHO survey showed a 29.0% of treatment gap [46]. This is also supported by a review from Africa using pathways to care, with an estimated pooled proportion ranging from 38% to 60.4% first treated by professionals [47]. The results underscore the need for professional service availability. Persons with depression are more likely to seek profession help if the services are easily and readily available, and if they or their close families have information about the services being available [47]. The study therefore suggested the need for improved availability of professional services for persons with depression, and for more information to be made available for the persons who need these services and their families. These findings are supported by the study by Coppens in four European

countries baseline survey, in which help-seeking for persons with depression was closely related with ease of access to professional services, among other factors [48].

Similarly, Dukoand (2018) reported in a comparative cross-sectional study on suicidal ideation and attempts among people with severe mental disorder in Addis Ababa, Ethiopia, that the effectiveness of the current mental health care system on the screening of depression and availability of modern treatment place/professionals were cardinal in improving utilization of professional services for person with depression [49]. On the other hand, scarce mental health resource has been reported as being another barrier to seek help from mental health professionals [48, 49].

Further, co-morbidity of surgical and medical illness has been reported to be significant to seek help from professionals for depressive symptoms. Individuals tend to visit health facilities for physical illnesses which indirectly lead them to the diagnosis of depression. This condition leads the individuals with depressive symptoms to seek professional help, since it is relatively not stigmatizing to seek help for most of the medical illnesses; hence, individuals with depressive symptoms who have co-morbid medical illnesses have higher rates of seeking professional help for acute medical complaints such as headaches or abdominal pain [38]. However, this can only work in cases where the health professionals are competent to diagnose depression and offer appropriate psychological and medical care. Hence, ability of health service provision point to attend to both the medical and psychiatric concerns of persons with depression increases the rates of professional help-seeking among persons with depression.

In another study, participants were asked if they had received help for mental health problems from a general practitioner, psychiatrist, psychologist, mental health institution, social worker, clinic for alcohol or drugs abuse, medical specialist, or if they had received day treatment for psychological problems in the past six months. Participants were considered to be “help-seeking” if they confirmed at least one contact with a mental health care provider in the past six months. Participants, who did not, were considered to be “non-help-seeking” [28]. In this and other studies, health system factors that affected help-seeking among persons with depression included health facility location being very far or being sparsely distributed, delayed provision of services and lack of sensitization by health workers [20,38].

METHODS

Study design

The study was a cross-sectional, descriptive and analytical in nature. It was cross sectional because only a portion of the study population was sampled at a point in time to represent the rest. It applied both quantitative and qualitative approaches. Quantitative approach was used for percentage description and statistical analysis techniques. Qualitative approach was used to get additional information from key informants regarding the help-seeking behaviours and their determinants among refugees and asylum seekers with depression.

Study area

The study was conducted at Kyaka II Refugee Settlement Camp, which is located in Kyegegwa District, western Uganda. Kyaka II encompasses 81.5 square kilometres in the three sub counties of Mpara, Kyegegwa and Kabweza in the eponymous Kyaka County. The settlement is divided into nine zones: Sweswe, Buliti, Bukere, Mukondo, Itambabiniga, Kakoni, Bwiriza, Byabakora and Kaborogota. Kyaka II’s refugee population has quadrupled since December 2017, following the arrival of tens of thousands of refugees and asylum seekers from DRC fleeing conflict and inter-ethnic violence in North Kivu and Ituri province. As of November 2019, Kyaka II had 113,000 refugees and asylum seekers already living in the settlement and was at the brim of reaching maximum capacity. Kyaka II is managed by the UNHCR and the Ugandan Office of the Prime Minister's Department of Refugees (OPM). This place was chosen for this study due to the high number of refugees and asylum seekers who suffer from depression and some of them report to the health facility late for treatment (Bujubuli Health Centre III records, 2019).

Study population

The study population comprised of adult persons comprising of refugees and asylum seekers who are 18 years of age and above, living in Kyaka II’s refugee camp and have been newly diagnosed with depression or had history of depression. In order to get additional information, the study also included selected leaders as key informants. These included local council leaders and village health teams within the camp.

Eligibility

Inclusion in the study: The study included only those who willingly consented in writing to participate in the study. Further, only those who had been in the refugee settlement for at least six months, diagnosed or not diagnosed but with history of depression in their past six months, were included in the study.

Exclusion from the study: The study excluded those who had lived in the camp for a period less than six months; as living in a different area was considered to be associated with different help-seeking behaviours.

Sample size determination

This sample size for this study was determined by the Kish (1996) formula for cross-sectional studies:

$$N = \frac{Z^2 P(1-P)}{\delta 2}$$

Where;

N= Required Sample Size;

Z = Standard normal deviate at 95% confidence interval corresponding to 1.96

δ = Absolute error between the estimated and true population

proportion (5%).

P = Population proportion of population with the factor under study. According to Charlson, et al. (2019), the proportion of mental disorder (Depression inclusive) is 22.1% (0.221) [15].

Substituting in the formula:

$$n = \frac{(1.96)^2 * 0.221(1-0.221)}{(0.05)^2} = \frac{(0.6613660144)}{(0.0025)} = 264.54$$

Hence, the sample size required for the study was 265persons, comprising refugees and asylum seekers who sought help in health facility and those who sought help elsewhere.

Sampling procedure

Sampling was done purposively using records at Bujubuli Health Centre III and records in the community. To reach the required sample of 265, a proportionate sample of those who sought help in health facility (Bujubuli HC III) and proportionate sample of those who sought help elsewhere within the community was determined. It yielded a systematic random sample of 74 persons who sought help in health facility and 163 persons who sought help elsewhere, respectively.

Data collection tools & procedures

The research tools included a structured questionnaire for getting data from the primary respondents and a semi-structured interview guide for obtaining additional information from key informants. Data from primary respondents (diagnosed or not diagnosed but with history of depression) was collected by survey method using researcher-administered questionnaire, whereby the researcher or assistant was asking the questions and the recording the responses on the questionnaire. Interviews were conducted in English where the respondents were comfortable being interviewed in English language. Where it was possible, the interviews were conducted with the help of an interpreter. Each interview lasted about 20-30 minutes. Data from key informants was collected through an interview using a key informant interview guide.

Study questionnaire: The questionnaire was developed in English basing on the fact that the refugees and asylum seekers are of different nationalities without a common local or national language. It was designed in sections. The first part was for obtaining the respondents' bio or socio-demographic data. The next part had questions for obtaining information on help-seeking behavior, and the third part had questions for obtaining data on the factors that are associated with the help-seeking behavior. It had both closed and open-ended questions. Closed-ended questions were aimed at enabling the researcher to get specific responses while open-ended questions were aimed at allowing respondents to offer detailed responses.

Interview guide: The interview guide for the key informants had only open-ended questions which were used to get elaborate responses from them. Eight key informants were interviewed; which ranged from community health workers to opinion leaders within the eligibility criteria of this study.

Quality control measures

Quality control measures included those for ensuring validity and reliability of research instruments, as well as the training of research assistants.

Validity: To measure validity, the study questionnaire was given to an external research expert who is well acquainted with content rating; who rated the contents for their relevancy in line with the study objectives.

The expert gave a rate of 1 or 2 for each of the items on the questionnaire depending on how each was deemed relevant for the study. The content validity index (CVI) was computed as below;

$$CVI = \frac{(Number\ of\ items\ declared\ valid\ by\ experts)}{(Total\ number\ of\ items\ on\ the\ instrument)}$$

According to the research experts, the number of items declared valid for the study was 26 while the total number of items on the instrument was 32.

Thus,

$$CVI = \frac{(26)}{(32)} = 0.8125 = 0.81$$

This gave a CVI score of 0.8 which is much higher than the 0.6 acceptable score given other scholars.

Reliability: For this study, reliability was ensured by standardizing the questionnaire through pre-testing it. The questionnaire was pre-tested on 30 refugees with depression in the same area, but outside the sampled categories. Pre-testing was done in order to assess whether the study questionnaire was easy to understandable by the respondents. After pre-testing, adjustments were made in the questions in order to make it user friendly for the study respondents.

Training of research assistants: Two research assistants were employed in the study to support during the data collection. The research assistants were diploma nursing students with experience in research and data collection. However, they had to undergo a competency-based training by the principal investigator to enable them to have good comprehension of the data collection procedures and other processes of the study before they can be utilized.

Data management and analysis

After collection, quantitative data was sorted and edited and then entered into the computerized statistical package for social scientists (SPSS) version 25. Different statistical methods were used. All objectives were analyzed using descriptive statistics of frequency and percentages. Thereafter, Chi-Square and multivariate logistic regression analysis was done to examine the determinants help-seeking behaviours. The significant level for all statistical analyses was set at $p \leq 0.05$. All the data related to this study has been made available in a public repository, mendeley [50]. From this, details about the data can be sought.

Ethical considerations

Research ethic committee of Uganda Martyrs University accepted the study, in compliance with standards set by Uganda National Council of Technology and Sciences (UNCTS). Informed consent was obtained from each of the study respondents before recruiting them to participate in the study. They were assured of confidentiality of their opinions and responses. Participating in the study was at free will, without compulsion or coercion.

Limitations of the study

This study was conducted in a refugee setting. Therefore, the outcomes or results might not be representatives for settings other than of refugee camps. Also, the study did not investigate the specific medico-surgical co-morbid conditions of refugees and asylum seekers with depression and did not assess whether the individuals who sought professional help got standard treatment or not. Therefore, inference on the study is confined to this study scope.

RESULTS

Socio-demographic characteristics of respondents

The study was set to interview 265 respondent refugees and asylum seekers but ended up obtaining data from 237 respondent refugees and asylum seekers, yielding a response rate of 89.4%, of which analysis was done. Details of socio-demographic characteristics are shown in **table 1**.

Table 1 Socio-demographic Characteristics of Study Respondents.

Characteristic	Frequency (n = 237)	Percent (%)
Gender		
Male	113	47.7
Female	124	52.3
Age in complete years		
18 – 30	83	35
31 – 40	64	27
41 – 50	42	17.7
Older than 50	48	20.3
Highest education level		
None	42	17.7
Primary	129	54.4
O’ Level	62	26.2
Tertiary	4	1.7
Marital status		
Married	154	65
Not married	83	35
Religion		
Roman Catholic	57	24.1
Protestant/ Anglican	103	43.5
Muslim	5	2.1
Other	72	30.4

The summary of results in table 1 above show that slightly more than a half, 124(52.3%) of the study respondents were female. In terms of age, depression affected mostly young people aged 18–30 years, 83(35.0%), while the least affected were those aged 41–50 years, 42(17.7%). More than a half, 129(54.4%) had primary level education, while more than a quarter, 62(26.2%) had O’ level education, followed closely by those who hadn’t acquired any level of formal education, 42(17.7%). Majority of them, 154(65.0%) were married. In terms of religion, majority, 103(43.5%) were Protestants/Anglican, while the Muslims, 72(30.4%) were the least.

Help-seeking behaviours of persons with depression or history of depression

To describe the help-seeking behaviours of refugees and asylum seekers with depression or history of depression in Kyaka II Refuge Settlement Camp in Kyegegwa District, **table 2** was drawn.

According to the summary of results in table 2 above, majority of the respondents, 79(33.3%) reported trying several measures in seeking help for depression, followed by those who sought help from spiritual leaders, 64(27.0%) and then closely those who went to a public health facility, 60(25.3%). Overall, only 74(31.2%) sought help from a health facility the first time they realised that they or their loved ones could be suffering from depression. While the majority of them, 153(64.6%) sought help within the first three months, a sizeable number of them, 35(14.8%) took more than six months to seek for medical treatment. A sizeable proportion of them, 43(18.1%) tried drugs to get relief from depression.

Table 2 Help-Seeking Behaviours of Persons with Depression.

Variable	Frequency (n = 237)	Percent (%)
Help-seeking behaviour for depression		
Government health facility	60	25.3
Private health Facility	14	5.9
Traditional healer	20	8.4
Spiritualist / religious leader	64	27
Tried several measures	79	33.3
Duration of seeking medical treatment on noticing/ suspecting depression		
Within 3 months	153	64.6
3 to 6 months	49	20.7
After six months	35	14.8

Tried drugs to get relief from depression		
Yes	43	18.1
No	194	81.9

In a qualitative interview, the findings on multiple help-seeking were also reported by the key informants, as can be observed in the quotes below:

"[…] people suffering from depression try out so many things in need of help […]" - (KI I, II and III)

This was also supported by the other key informants, as can be observed in the quotes below:

"[…] most of them first seek other means before finally choosing to come to the health centre […]" - (KI I)

"[…] some first try getting help from people who pray for them […] and traditional healers […] only to remember about going to the health centre after failing with those means"- (KI II & III)

Seeking help from unprofessional places was also pointed out by key informants as highlighted in the quotes bellow:

"[…] some go to traditional healers […]"- (KI II & VII)

"[…] some go to be prayed for […] hoping that prayer works […]"- (KI I & IV)

Personal factors that influenced help-seeking behaviours

According to the summary of results indicted in **table 3**, more than three quarters, 197(83.1%) of the study respondents were from the Democratic Republic of Congo (DRC). Close to a half, 117(49.4%) of them had been refugees for more than 5 years, followed closely by 105(44.3%) who had been refugees for between 1–5 years. Majority, 117(49.4%) had been at Kyaka II Refuge Settlement Camp for more than five years. Majority of them, 152(64.1%) did have any employment before they became refugees, while the least, 3(1.3%) were in formal/salaried employment. Further, majority of them, 167(70.5%) didn't have any source of income at the moment, and for those who had, 70(29.5%), a good number of them, 57(24.1%) were peasant farmers, with a few market vendors and shop traders. More than three quarters, 182(76.8%) didn't have an average monthly income, while for those who had, only 19(8.0%) were earning at least 100,000/- on average per month.

Table 3 Personal Factors Associated with Help-Seeking Behaviours of Persons with Depression.

Factors	Frequency (n = 237)	Percent (%)
Country of origin		
Congo (DRC)	197	83.1
Other countries (Rwanda, Burundi)	40	16.9
Years as a refugee		
Less than one	15	6.3
1 to 5 years	105	44.3
More than 5 years	117	49.4
Duration in Kyaka II refugee camp		
Less than 1year	21	8.9
1 – 5years	99	41.8
More than 5years	117	49.4
Nature of employment before becoming a refugee		
Formal/salaried employment	3	1.3
Business	82	34.6
None	152	64.1
Has source of income		
Yes	70	29.5
No	167	70.5
Type of income source		
Peasant Farmer	57	24.1
Market Vendor	6	2.5
Shop Trader	7	3
Not applicable (No income source)	167	70.5
Average income per month		
None	182	76.8
<100,000/=	36	15.2
100,000/= or more	19	8
Correctly define depression		

Yes	201	84.8
No	36	15.2
Think depression is a condition to worry about		
Yes	208	87.8
No	29	12.2
Reasons why depression is a serious condition		
Causes health complications	29	12.2
Leads to poverty	92	38.8
A great cause of death	42	17.7
Brings about violence	17	7.2
Causes despair	28	11.8
N/A (no need to worry about it)	29	12.2
Think refugees have increased risk of suffering from depression		
Yes	224	94.5
No	13	5.5
Reasons for increased risk of suffering depression		
Poverty	68	28.7
Inadequate services in the camp	77	32.5
War effects	79	33.3
N/A (Doesn't think so)	13	5.5
on	on	on
Knows the signs and symptoms of depression		
Yes	222	93.7
No	15	6.3
The known signs and symptoms of depression		
Any of the following: sadness, low moods, lack of sleep, lack of appetite, difficulty in thinking	222	93.7
N/A (Doesn't know)	15	6.3
Takes alcohol		
Yes	54	22.8
No	183	77.2
Frequency of alcohol consumption		
Every day	12	5.1
Once a week	36	15.2
Once a month	6	2.5
Not Applicable (Doesn't take)	183	77.2
Challenges due to depression		
Any of the following: Difficulty accessing services, family breakups, difficulty in getting employment, stigma	228	96.2
NA (No challenges)	9	3.8

According to summary of results in table 3, more than three quarters, 201(84.8%) of study respondents were able to correctly define depression, and 208(87.8%) of them were of the view that depression is worth worrying about, mainly because “it leads to poverty, causes death, causes other health complications, causes despair, and brings about violence. Almost all, 224(94.5%) of them were of the view that refugees have increased risk of suffering from depression, mainly due to inadequate services in the camp, effects of war, and poverty. Almost all, 222(93.7%) of them knew the signs and symptoms of depression, including sadness, low moods, lack of sleep, lack of appetite, and difficulty in thinking. More than three quarters of them, 183(77.2%) reported that they do not take alcohol, but a sizeable number of them, 54(22.8%) reporting that they take alcohol; most of them taking it at least once a week. Almost all, 228(96.2%) reported experiencing challenges due to depression, including difficulties in accessing services, family breakups, difficulty in getting employment, and stigma.

To achieve the objective determining the personal factors, the

different personal factors (including demographic characteristics) were first subjected to Pearson Chi square (χ^2) tests in order to identify those that significantly influence the help-seeking behaviours of persons with depression at the camp [**Table 4**].

Table 4 Possible Demographic Factors that Influenced the Help-Seeking Behaviors of Persons with Depression or History of Depression.

	Help-Seeking Behavior					Odd Ratios	
Factor	Health Facility Freq. (%)	Not Health Facility Freq. (%)	χ^2	Df	p-value	COR (CI; 95%)	AOR (CI; 95%)
Gender							
Male	28(24.7%)	85(75.2%)	4.177	1	0.028*	0.56(0.319-0.979)*	0.61(0.309-1.186)
Female	46(37.1%)	78(62.9%)				1	
Age							
≤ 40 years	50(34.0%)	97(66.0%)	1.403	1	0.15		
> 40 years	24(26.7%)	66(73.3%)					
Education Level							
None	16(38.1%)	26(61.9%)	1.122	1	0.19		
Some Education	58(29.7%)	137(70.3%)					
Marital status							
Married	37(24.0%)	117(76.0%)	10.608	1	0.001**	0.39(0.223-0.695)**	0.52(0.262-1.017)
Not married	37(44.6%)	46(55.4%)				1	
Religion							
Protestant	43(41.7%)	60(58.3%)	9.395	1	0.002**	2.38(1.359-4.172)**	2.2.62(1.358-5.5.046)**
Other religions	31(23.1%)	103(76.9%)				1	

*p < 0.05 **p < 0.01 RC = 1, COR=Crude Odd Ratio, AOR=Adjusted Odd Ratio

According to the summary of results in table 4, basing on Chi-square (χ^2) analysis, the only demographic factors that were found to have an influence on help-seeking behaviour were gender (p=0.028), marital status (p=0.001) and religion (p=0.002). As such, age and formal education level were not found to significantly influence the help-seeking behaviours of persons with depression in Kyaka II Refuge Settlement Camp in Kyegegwa District.

The demographic variables that showed significant association under Chi-square analysis (gender, marital status and religion) were subjected to Logistic linear regression to obtain Crude Odds Ratios (COR) and corresponding 95% Confidence Intervals (CI). The significant variables after Logistic linear regression were further subjected to multivariate analysis to get the Adjusted Odds Ratios (AOR) and corresponding 95% CI.

According to results in table 4, gender significantly influenced the help-seeking behaviors of persons with depression in Kyaka II Refuge Settlement Camp in Kyegegwa District (COR=0.56, 95% CI=0.319-0.979, p=0.042), implying that men were about 0.5 times less likely to seek help for depression from a health facility than their female counterparts. However, on subjecting to multivariate analysis, gender was not found to be significant in influencing the help-seeking behaviors of persons with depression in Kyaka II Refuge Settlement (AOR=0.61, 95% CI=0.309-1.186, p=0.143). This in effect imply that there were confounding factors which could have led gender to appear as having an influence on the help-seeking behaviors of persons with depression in Kyaka II Refuge Settlement Camp in Kyegegwa District.

According to results in table 4, marital status significantly influenced the help-seeking behaviours of persons with depression in Kyaka II Refuge Settlement Camp in Kyegegwa District (COR=0.39, 95% CI=0.223-0.695, p=0.001), implying that those who were married were at least 0.4 times less likely to seek help for depression from a health facility than those who were not married. However, on subjecting to multivariate analysis, marital status was not found to be significant in influencing the

help-seeking behaviors of persons with depression in Kyaka II Refuge Settlement Camp in Kyegegwa District (AOR=0.52, 95% CI=0.262-1.017, p=0.056).

According to results in table 4, religion significantly influenced the help-seeking behaviours of persons with depression (COR=2.38, 95% CI=1.359-4.172, p=0.002), implying that those who were protestants were at least two times more likely to seek help for depression from a health facility than those who belonged to other religions. On subjecting to multivariate analysis, religion was still found to be significant in influencing the help-seeking behaviours of persons with depression in Kyaka II Refuge Settlement (AOR=2.62, 95% CI=1.358-5.046, p=0.004). This is in an implication that belong to the Protestant/Anglican religion was about three times essential in influencing the help-seeking behaviours of persons with depression in Kyaka II Refuge Settlement Camp in Kyegegwa District.

According to results in **table 5**, basing on Chi-square (χ^2) analysis, the only other personal factors that were found to have an influence on help-seeking behaviour were number of years as a refugee (p=0.000), duration as a refugee in Kyaka II camp (p=0.000), being able to correctly define depression (p=0.000), and being aware that refugees have increased risk of suffering from depression (p=0.049).

Table 5 Possible Personal Factors that Influence the Help-Seeking Behaviors of Persons with Depression or History of Depression.

	Help-Seeking Behavior					**Odd Ratios**	
Factors	**Health Facility Freq. (%)**	**Not Health Facility Freq. (%)**	χ^2	**df**	**p-value**	**COR (CI; 95%)**	**AOR (CI; 95%)**
Country of origin							
DRC	60(30.5)	137(69.5)	0.32	1	0.348		
Other countries	14(35.0)	26(65.0)					
Years as a refugee							
≤5	55(45.9)	65(54.1)	24.16	1	0.000**	4.364 (2.375-8.021)**	9.700(2.082-45.207)**
> 5	19(16.2)	98(88.8)				1	
Duration in Kyaka II refugee camp							
≤5 years	53(44.2)	67(55.8)	18.962	1	0.000**	3.616 (1.997-6.549)*	0.456(0.100-2.077)
More then 5	21(17.9)	96(82.1)				1	
Had employment before becoming a refugee							
Yes	24(28.2)	61(71.8)	0.551	1	0.277		
No	50(32.9)	102(67.1)					
Has source of income							
Yes	22(31.4)	48(68.6)	0.002	1	0.54		
No	52(31.1)	115(68.9)					
Average income per month							
<100,000	67(30.7)	151(69.3)	0.304	1	0.376		
≥100,000	7(36.8)	12(63.2)					
Correctly define depression							
Yes	53(26.4)	148(73.6)	14.527	1	0.000**	0.256 (0.123-0.532)*	0.398(0.172-0.920)*
No	21(58.3)	15(41.7)				1	
Think depression is a condition to worry about							
Yes	67(32.2)	141(67.8)	0.773	1	0.257		
No	7(24.1)	22(75.9)					
Think refugees have increased risk of suffering from depression							

Yes	73(32.6)	151(67.4)	3.547	1	0.049*	1.493(0.608-3.669)*	0.872(0.285-2.673)
No	1(7.7)	12(92.3)				1	
Alcohol use							
Yes	15(27.8)	39(72.2)	0.387	1	0.328		
No	59(32.2)	124(67.8)					
Challenges due to depression							
Yes	73(32.0)	155(68.0)					
No	1(11.1)	8(88.9)	1.762	1	0.17		

As such, country of origin, employment status before becoming a refuge, current employment status and income, thinking that depression is a condition to worry about, alcohol use, and experiencing challenges due to depression were not found to significantly influence the help-seeking behaviors of persons with depression in Kyaka II Refuge Settlement Camp in Kyegegwa District.

The other personal variables that showed significant association under Chi-square analysis (years as a refugee, duration at Kyaka Refugee Resettlement, being able to correctly define depression, and the perception or thinking refugees have increased risk of suffering from depression) were subjected to Logistic linear regression to obtain Crude Odds Ratios (COR) and corresponding 95% Confidence Intervals (CI). The significant variables after Logistic linear regression were further subjected to multivariate analysis to get the Adjusted Odds Ratios (AOR) and corresponding 95% CI.

According to results in table 5, years spent as a refuge was found to significantly influence the help-seeking behaviours of persons with depression (COR=4.364, 95% CI=2.375-8.021, p=0.000), implying that those who have been refugees for a period less or equal to five years were about four times more likely to seek help for depression from a health facility than their counterparts who had been refugees for a period of greater than five years. On subjecting to multivariate analysis, number of years spent as a refuge were still significant in influencing the help-seeking behaviors of persons with depression (AOR=9.700, 95% CI=2.082-45.207, p=0.004). This in effect implies that those who have been refugees for a period less or equal to five years were about ten times more likely to seek help for depression from a health facility than their counterparts who had been refugees for a period of greater than five years.

According to results in table 5, number of years spent as a refuge in Kyaka II was found to significantly influence the help-seeking behaviors of persons with depression in (COR=3.616, 95% CI=1.997-6.549, p=0.000), implying that those who have been refugees in Kyaka II for a period less or equal to five years were about four times more likely to seek help for depression from a health facility than their counterparts who had been there for a period of greater than five years. However, on subjecting to multivariate analysis, number of years spent as a refuge in Kyaka II was found not to significantly influence the help-seeking behaviours of persons with depression (AOR=0.456, 95% CI=0.100-2.077, p=0.310), an indication that there were confounding factors that caused the number of years spent as a refugee in Kyaka II to appear to be significant in influencing the help-seeking behaviors of persons with depression.

According to results in table 5, being able to correctly define depression was found to significantly influence the help-seeking behaviours of persons with depression or history of depression (COR=0.256, 95% CI=0.123-0.532, p=0.000). Further, on subjecting to multivariate analysis, being able to correctly define depression was still found to be significant in influencing the help-seeking behaviors of persons with depression in Kyaka II (AOR=0.398, 95% CI=0.172-0.920, p=0.031).

According to results in table 5, the thinking that refugees have increased risk of suffering from depression was found to significantly influence the help-seeking behaviours of persons with depression (COR=1.493, 95% CI=0.608-3.669, p=0.049), with those who thought so being 1.5 times more likely to seek help from health facility.

In qualitative interviews, some of the key informants said, highlighting that gender is key in help-seeking for depression, as can be observed in the quotes below;

"[…] females tend to go for treatment early […] men tend to delay and come when it is a bit late […]"- (KI III)

"[…] women are better than men […] they tend to look for help early […]" - (KI I & II)

However, in contrasted with what was highlighted by some of the key informants that marital status plays a role in help-seeking for depression, the following views were noted observed in the quotes below:

"[…] those who are married have social support […] which enables them to seek treatment early […]"- (KI I)

"[…] marriage plays a key role in help-seeking behaviour […]"- (KI III)

Health system factors that influenced the help-seeking behaviours

Several health system factors were assessed for whether they have any influence on the help-seeking behaviours of persons with depression or history of depression in Kyaka II Refuge Settlement Camp in Kyegegwa District. These included the

availability of healthcare services for depression and patients being knowledgeable about the existence of those services, health workers visiting the camp to sensitize about depression, patients receiving services when needed, client experience with services at healthcare facility, and if there are other available support for persons with depression [**Table 6**].

Table 6 Health System Factors Associated with Depression Help-Seeking Behaviours.

Factor	Frequency (n = 237)	Percent (%)
Knows that there are healthcare services for depression		
Yes	187	78.9
No	50	21.1
Mentioned healthcare services for persons with depression		
Counselling	91	38.4
Medical treatment	96	40.5
NA (No known services)	50	21.1
Health workers always visit to sensitize about depression		
Yes	34	14.3
No	203	85.7
Receive services when needed		
Yes	115	48.5
No	122	51.5
Experience with services at healthcare facility		
Bad	116	48.9
Good	71	30
Fair	50	21.1
There are other available support for persons with depression		
Yes	44	18.6
No	193	81.4
The other available services for persons with depression		
Counselling	44	18.6
NA (No other services)	193	81.4

According to the summary of results in table 6, more than three quarters of the study respondents, 187(78.9%) reported that there were healthcare services for depression, especially counseling and medical treatment. However, according to the majority of them, 203(85.7%) health workers do not always visit the camp to sensitize them about depression. Further, slightly more than a half of them, 122(51.5%) reported that they didn't always receive healthcare services at the health facility when they needed them, and almost a half of them, 116(48.9%) reported bad experience with services they received at healthcare facility. According to majority of the study respondents, 193(81.4%) there were no other available support for persons with depression at Kyaka II Refuge Settlement.

Objective 3 of the study was to determine the health system factors that influence the help-seeking behaviours of persons with depression in Kyaka II Refuge Settlement. To achieve this, the different health system factors were first subjected to Pearson Chi square (χ^2) tests to determine the significant influence on help-seeking behaviours.

According to the summary of results in **table 7**, basing on Chi-square (χ^2) analysis, there was no statistical significance between most health system factors and help seeking behaviours, except receiving services when needed (p=0.000) and experience at healthcare facility (p=0.000). The other factors, such as service availability, health workers visiting the camp to sensitize them about depression, and other available health services were not found to significantly influence help-seeking behaviours of persons with depression or history of depression in Kyaka II Refuge Settlement Camp in Kyegegwa District.

The health system variables that showed significant association under Chi-square analysis (receiving services when needed and experience with services at healthcare facility) were subjected to Logistic linear regression to obtain Crude Odds Ratios (COR) and corresponding 95% Confidence Intervals (CI). The significant variables after Logistic linear regression were further subjected to multivariate analysis to get the Adjusted Odds Ratios (AOR) and corresponding 95% CI.

Thus, as shown in table 7, receiving services when needed was

found to significantly influence the help-seeking behaviors of persons with depression in Kyaka II Refuge Settlement Camp in Kyegegwa District (COR=2.881, 95% CI=1.622-5.116, p=0.000), implying that those who received services when they needed them were about three times more likely to seek help for depression from a health facility than their counterparts who were not receiving services when they needed them.

Table 7 Possible Health System Factors that Influence the Help-Seeking Behaviors of Persons with Depression.

	Help-Seeking Behavior						
Factor	**Health Facility Freq. (%)**	**Not Health Facility Freq. (%)**	**χ^2**	**df**	**p-value**	**COR (CI; 95%)**	**AOR (CI; 95%)**
Knowledge of availability of healthcare services for depression							
Yes	62(33.2)	125(66.8)	1.54	1	0.142		
No	12(24.0)	38(76.0)					
Health workers always visit to sensitize about depression							
Yes	14(41.2)	20(58.8)	1.831	1	0.125		
No	60(29.6)	143(70.4)					
Receive services when needed							
Yes	49(42.6)	66(57.4)	13.485	1	0.000**	2.881(1.622-5.116)**	1.948(0.865-4.386)
No	25(20.5)	97(79.5)					
Experience with services at healthcare facility							
Bad	24(20.7)	92(79.3)	11.74	1	0.000**	0.370(0.208-0.660)**	0.734(0.327-1.649)
Good or fair	50(41.3)	71(58.7)					
Other available support for persons with depression							
Yes	17(38.6)	27(61.4)	1.383	1	0.16		
No	57(29.5)	136(70.5)					

*p < 0.05   **p < 0.01   RC = 1

Again, experience with services received at the health centre was found to significantly influence the help-seeking behaviours of persons with depression in Kyaka II Refuge Settlement Camp in Kyegegwa District (COR=0.370, 95% CI=0.208-0.660, p=0.001) (Table 7). However, on subjecting to multivariate analysis, experience with services received at the health centre was found not to significantly influence the help-seeking behaviours (AOR=0.734, 95% CI=0.327-1.649, p=0.454).

Discussion

Help-seeking behaviours of persons with depression or history of depression

According to the current study results all the refugees and asylum seekers with depression at Kyaka II Refugee Settlement Camp did something in search for help due to depression. This contradicts with Wallerblad, et al. (2012) who highlighted that low help seeking for depression is common and that it is the main reason that increases the burden and complexity of depressive disorders [26]. Majority of the respondents with depression or history of depression at Kyaka II Refugee Settlement Camp, 79(33.3%) tried several measures in seeking help for depression. Probably this is due to the challenges associated with depression as highlighted, and the fact that majority of them considered depression to be a serious disease which can cause health complications, leads to poverty, it's a great cause of death, brings about violence and causes despair. This could have caused them to have multiple help-seeking strategies in order to have relief or a solution from these several concerns. It is also worth noting, however, that only 74(31.2%) persons in this current study sought help from a health facility the first time they realised that they or their loved ones could be suffering from depression. This finding is similar to what has been reported by other studies which found low rate of professional help-seeking per persons suffering from depression [27-29].

In the current study, the rate of seeking unprofessional help for depression was relatively high as 64(27.0%) sought the help of spiritualists/religious leader and 20(8.4%) contacted traditional healer. This could be attributed to the worries they had about the disease which made them to seek interventions of spiritualist/religious and traditional healers. This finding is however, supported by Conner, et al. (2010) and Wallerblad et al. (2012) who also reported use of spiritualist in help seeking for depression [26,30].

Personal factors influence the help-seeking behaviours of persons with depression

In the current study, based on Chi-square (χ^2) analysis, the only personal factors that were found to have an influence on help-seeking behaviour were gender (p=0.028), marital status (p=0.001), religion (p=0.002), number of years as a refugee (p=0.000), duration as a refugee in Kyaka II camp (p=0.000), being able to correctly define depression (p=0.000), and being aware that refugees have increased risk of suffering from depression (p=0.049). This can be attributed to the factors such as gender, marital status and religion being important ingredients in society that can cause community members to benefit from. These factors have also been highlighted by other studies to be essential in promoting helping among persons suffering from depression. Melak, et al. (2018) for example in a study in Ethiopia, reported that being female and being married were significantly associated with professional help-seeking for depression [28].

Furthermore, female gender was found to significantly influence the help-seeking behaviours of persons with depression in Kyaka II Refuge Settlement Camp in Kyegegwa District (COR=0.559, 95% CI=0.319-0.979, p=0.042), probably because females are fond of having favorable health seeking behaviours than men. This disagrees with Melak, et al. (2018) who in a study in Ethiopia reported that being female [AOR=2.769, 95% CI (1.280, 5.99)] was significantly associated with help seeking for depression [28].

In the current study, marital status was found to significantly influence the help-seeking behaviors of persons with depression in Kyaka II Refuge Settlement Camp in Kyegegwa District (COR=0.393, 95% CI=0.223-0.695, p=0.001). Probably, marriage is associated with important social support, which leads to improved help seeking, as was also reported by Conner et al. (2010) and Wallerblad, et al. (2012) [26,30]. This however, contrasted with what was highlighted by some of the key informants that marital status plays a role in help-seeking for depression.

In the current study, religion significantly influenced the help-seeking behaviors of persons with depression in Kyaka II Refuge Settlement Camp in Kyegegwa District even on multivariate analysis (AOR=2.617, 95% CI=1.358-5.046, p=0.004). In essence, belonging to the Protestant/Anglican religion was about three times essential in influencing the help-seeking behaviors of persons with depression in Kyaka II Refuge Settlement Camp in Kyegegwa District. Belonging to this religious group probably offered the victims of depression some relief in terms of support such as counselling given which wasn't offered by other religious groups. However, unlike the current study, other studies did not find religion to be significant in influencing help seeking for persons with depression [26,30,41]. Nonetheless the differences in findings can probably be attributed to differences in study settings with the current study being conducted in a refugee setting where probably due to emotional and other stressful challenges, refugees seek relief from religion.

In the current study, personal factors such as age, formal education level, alcohol or drug use were not found to significantly influence the help-seeking behaviours of persons with depression. Probably this was because the study was conducted in a refugee setting where the residents probably don't have a lot of freedom when it comes to pursuing education or use of alcohol and other drugs. Nonetheless, some studies have found age, formal education level, alcohol or drug use as being significant in influencing the help-seeking behaviours of persons with depression [26,30,43 and 44].

The number of years spent as a refuge was found to significantly influence the help-seeking behaviors of persons with depression in Kyaka II Refuge Settlement Camp in Kyegegwa District (COR=4.364, 95% CI=2.375-8.021, p=0.000). Similarly, the number of years spent as a refuge in Kyaka II Camp was found to significantly influence the help-seeking behaviours of persons with depression in Kyaka II Refuge Settlement Camp in Kyegegwa District (COR=3.616, 95% CI=1.997-6.549, p=0.000). This is however contrasted by Chen, et al. (2013) who reported higher rates of professional help seeking for depression among those who had been refugees for a long period (more than five years).

Health system factors influencing the help-seeking behaviours

Basing on Chi-square (χ^2) analysis, the only health system factors that were found to significantly influence the help-seeking behaviours of persons with depression in Kyaka II Refuge Settlement Camp in Kyegegwa District were receiving services when needed (p=0.000) and experience at healthcare facility (p=0.000). These findings are however in line with previous studies which reported experience and service availability are essential in influencing the health seeking behaviors of patients [48,49].

Conclusion

At Kyaka II Refuge Settlement Camp in Kyegegwa District, refugees and asylum seekers suffering from depression try out several measures in seeking help for their depression predicament. However, only a sizeable proportion of them seek professional care on realizing that they are suffering from depression. Instead, some of them seek relief from spiritualists/religious leaders and sometimes even traditional healers. The help-seeking behaviours are influenced mainly by gender, marital status, religion, number of years as a refugee, duration as a refugee in Kyaka II camp, being able to correctly define depression, being aware that refugees have increased risk of suffering from depression, receiving services when needed and experience with services received at the health centre. Nonetheless, seeking professional help for depression among refugees and asylum seekers at Kyaka II Refugee Settlement Camp is mainly determined by being married, belonging to protestant religion, having been a refuge for less or equal to five years, and being able to correctly define depression.

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The authors, OK & KM, made equal contributions to production and publication of this study.

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